



GREY AREAS NEWSLETTER

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

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Learning from Other Regulatory Systems

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Canadian policy makers and regulators have been looking to other countries for insights into, and alternative ways of, regulating professions. Generally, the systems examined are from the United Kingdom, Australia, New Zealand, and the United States. To a lesser extent, regulators have looked to the European Economic Community. Rarely have regulatory systems elsewhere been examined in detail.

A recent exception is the open access article by McGivern, G., Wafula, F., Seruwagi, G. et al. entitled Deconcentrating regulation in low- and middle-income country health systems: a proposed ambidextrous solution to problems with professional regulation for doctors and nurses in Kenya and Uganda. *Hum Resour Health* 22, 13 (2024). <https://doi.org/10.1186/s12960-024-00891-3>.

In setting out the background to the article, the authors state:

However, there is a human-resources for health crises in many LMICs. There are too few health

workers. Pay is often poor and irregular. Many health workers are demotivated. Strikes, absenteeism, nepotism and malpractice are widespread.

We examine how regulation of health workers may contribute towards or mitigate these problems. Regulation can enhance health workers' professional practice. However, it is often weakly implemented and enforced in LMIC health systems. This is due to reasons including regulators having limited resources, regulatory capture, and corruption [*citations omitted*]

Canadian health practitioners and regulators face some similar issues, as well, albeit to a different degree and in different ways. For example, the shortage of health care practitioners in Canada has undoubtedly resulted in greater political involvement in modifying registration requirements and registration policies and procedures. (A rapidly emerging dashboard measurement of effectiveness of Canadian health profession

regulators is whether they are registering more applicants, especially internationally trained ones, than in previous years.) However, the concept of professional regulatory staff having the authority to arrest registrants for misconduct is inconceivable in Canada (as is mentioned in passing in the article).

The authors used various research methods to obtain data including interviews, surveys, and focus groups. The following themes emerged:

- “Regulation in both the Kenyan and Ugandan health systems was generally perceived as ‘weak’. Kenyan and Ugandan regulators were seen to have inadequate resources and staff, to be ‘remote’, ‘out of touch’ with clinical practice ‘on the ground’, and more focused on collecting licencing fees than regulating professional practice.”
- “Interviewees also described weak regulation and declining standards of training, internships, supervision, and mentoring of health professionals. This was seen to be undermining professionalism, skills, and knowledge.”
- “Interviewees were also positive about regulation where they had relationships with accessible local regulators.”

The research produced some novel findings:

First, online (re)licencing was seen as quick, easy, and effective. Second, health professionals were more positive about regulation where they had relationships with accessible regulators. These novel findings reflect ‘responsive’ and ‘relational’ regulation theory, which hypothesise that good regulatory relationships enhance understanding of how and why people should comply, so increase compliance, and improve

regulators’ understanding of compliance levels and how to improve regulation. *[citations omitted]*

The authors proposed a new organizational model for professional regulation.

We propose deconcentrating regulation by developing subnational regulatory offices connected to a common national structure. This is distinct from decentralisation, which involves independent governance at subnational level. Our findings raise concerns about decentralised independent regulators lacking resources, expertise and undermining common national standards of professional regulation and practice. Deconcentrating regulation would also bring regulators closer to professional practice, enabling them to better detect and address problems, but while sharing national resources, expertise, information, learning and standards. Common problems in subnational areas could then be addressed by improving national regulatory standards, training, or guidance in ways reflecting learning in responsive regulation theory. *[citations omitted]*

Some Canadian regulators have retained or adopted strategies that may partially reflect this concept. For example, some regulators have local chapters, carried over from the days when the regulator was also the professional association, that can provide local input and communication. Many regulators conduct “road shows”, now often done remotely, when consulting on and implementing major policy changes. Some regulators use local registrants and staff to conduct inspections and quality assurance assessments, which is often better received than sending representatives from capital cities.

This deconcentrating regulation model may become more important if Canada moves to the national regulation of health professions.

This research into regulation of professions in other countries has a collateral benefit for Canadian regulators. With the rapid increase in the registration of internationally trained applicants, Canadian regulators can advance the orientation services they

provide to new registrants that appreciates educational, cultural, and regulatory diversity to better bridge inclusion within the Canadian system.

Regulators can benefit from learning from the regulatory systems around the globe.

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